YOUR MEDICARE BENEFITS

This is the official government booklet with important information about:

Your Health Care Coverage in the Original Medicare Plan

▶ Coverage and payment charts begin on page 14.
How do you find what you need? See index on pages 2 - 3.

CENTERS FOR MEDICARE & MEDICAID SERVICES

INTRODUCTION

Welcome!

This booklet explains your Medicare benefits in the Original Medicare Plan (sometimes called "fee-for-service") in 2004.

A benefit is a health care service or supply that is paid for in part or in full by Medicare.

It's important to know that Medicare doesn't cover everything. Medicare doesn't pay the total cost for most covered services or supplies. Talk to your doctor to be sure you get the service or supply that best meets your health care needs.

This booklet explains

- Medicare basics.
- Which health care services and supplies are covered in the Original Medicare Plan (sometimes called "fee-for-service"), when they are covered, and how much you pay.
- Where to get help with your questions.

Medicare Advantage Plans (formerly Medicare + Choice Plans)

You can get your coverage through the Original Medicare Plan, or from a Medicare Advantage Plan (formerly Medicare + Choice Plan). Congress created the Medicare Advantage Program to give you more choices, and sometimes, extra benefits, by letting private companies offer you your Medicare benefits. If you join a Medicare Advantage Plan, you may have the following choices:

- Medicare Managed Care Plans,
- Medicare Preferred Provider Organization Plans, and
- Medicare Private Fee-for-Service Plans.

If Medicare Managed Care Plans, Medicare Preferred Provider Organization Plans, or Medicare Private Fee-for-Service Plans are available in your area, you can join one and get your Medicare benefits through the plan. By joining one of these Medicare Advantage Plans, you can often get extra benefits, like coverage for prescription drugs or additional days in the hospital. The plan may have special rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

Medicare Advantage Plans are available in many areas of the country. For information about the Medicare Advantage Plans available in your area, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder." Or, call 1-800-MEDICARE(1-800-633-4227). TTY users should call 1-877-486-2048.

"*Your Medicare Benefits*" isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

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Note: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date information, look at www.medicare.gov on the web. Select "Your Medicare Coverage." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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MEDICARE BASICS

Medicare is a health insurance program for

- People age 65 or older.
- People under age 65 with certain disabilities.
- People of all ages with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Original Medicare has two parts: Part A and Part B

Part A (Hospital Insurance). See page 5. Most people pay for Part A through their payroll taxes when they are working.

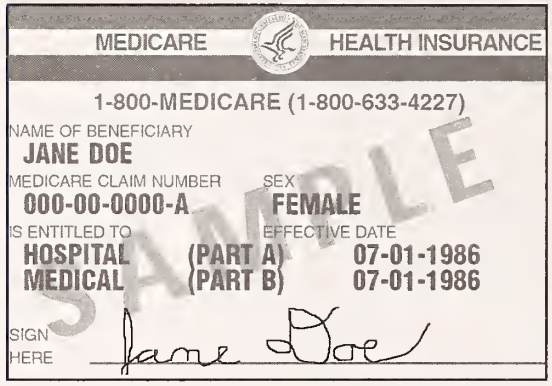
Part B (Medical Insurance). See page 5. Most people pay a monthly premium for Part B.

Do you need to replace your Medicare card?

You can order a replacement Medicare card at www.socialsecurity.gov on the web, or call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your Medicare Card

The parts of Medicare you have are printed on the lower left corner of your card.



Note: There are earlier versions of this card that are slightly different. They are still valid.

MEDICARE BASICS

What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. You must meet certain conditions.

Cost: Most people don't have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) didn't pay Medicare taxes while you worked and you are age 65 or older, you may be able to buy Part A. If you aren't sure if you have Part A, look on your red, white, and blue Medicare card (see sample card on page 4). If you have Part A, "Hospital (Part A)" is printed on the lower left corner of your card. You can also call the Social Security Administration at 1-800-772-1213 for more information about buying Part A. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

What is Medicare Part B?

Medicare Part B (Medical Insurance) helps cover your doctors' services and outpatient hospital care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Cost: You pay the Medicare Part B premium of $66.60 per month in 2004. This amount will change January 1, 2005. In some cases, this amount will be higher if you didn't sign up for Part B when you first became eligible. The cost of Part B may go up 10% for each full 12-month period that you could have had Part B but didn't sign up for it. You will have to pay this extra amount as long as you have Part B, except in special cases.

For more information about enrolling in (joining) Medicare, look in your copy of the *Medicare & You* handbook or call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Words in blue are defined on pages 45-46.

INTRODUCTION TO MEDICARE HEALTH PLANS

How do you get your Medicare health care?

Medicare offers you different ways to get your Medicare benefits. These include the Original Medicare Plan and Medicare Advantage Plans (formerly Medicare + Choice). How you get your health care in the Medicare program depends on which plan you choose. Depending on where you live, you may have more than one plan to choose from.

In 2004, Medicare offers the following types of Medicare health plans:

- The Original Medicare Plan (sometimes called "fee-for-service") - Everyone eligible for Medicare can join the Original Medicare Plan. This plan is available nationwide. Many people in the Original Medicare Plan also have a Medigap Policy (Medicare Supplement Insurance) that is offered by private companies to help pay health care costs that this plan doesn't cover. See page 10.
- Medicare Advantage Plans (formerly Medicare + Choice Plans) - You can get your coverage through the Original Medicare Plan or Medicare Advantage Plans. Congress created the Medicare Advantage Program to give you more choices, and, sometimes, extra benefits, by letting private companies offer you your Medicare benefits. The Medicare Advantage Plan you choose may include the following:
  - Medicare Managed Care Plans,
  - Medicare Preferred Provider Organization Plans, and
  - Medicare Private Fee-for-Service Plans.

NOTE: Medicare Advantage Plans must cover at least the same benefits covered by Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, like coverage for prescription drugs or additional days in the hospital. You may have to pay a monthly premium for the extra benefits.

For more information about Medicare health plans, see the *Medicare & You* handbook. This handbook is mailed to all people with Medicare each fall. To order a free copy, see page 44. To find out which Medicare health plans are located in your area, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder," or call 1-800-MEDICARE (1-800-633-4227). Follow the instructions to speak to a Customer Service Representative who will help you with the "Medicare Personal Plan Finder." You will get your results in the mail within three weeks. The Medicare Personal Plan Finder can help you make an informed health plan choice.

This booklet explains your coverage in the Original Medicare Plan.

THE ORIGINAL MEDICARE PLAN

What is the Original Medicare Plan?

The Original Medicare Plan is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care (see the sample card on page 4). If you are happy getting your health care this way, you don't have to change. You will stay in the Original Medicare Plan unless you choose to join a Medicare Advantage Plan.

How does the Original Medicare Plan work?

- You may go to any doctor or specialist that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. Generally, a fee is charged each time you get a health care service. If you go to a doctor, specialist, hospital, or other facility that doesn't accept Medicare, Medicare won't pay for the service.
- If you have Medicare Part A, you get all the Part A-covered services listed in the charts on pages 14-43.
- If you pay the monthly Part B premium ($66.60* in 2004), you get all the Medicare Part B-covered services listed in the charts on pages 14-43.
- Before Medicare pays its part, you pay a set amount for your health care (deductible): $876 for Part A and $100 for Part B in 2004. The Medicare Part B deductible will go up to $110 in 2005. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).
- After you get a health care service, each month you get a Medicare Summary Notice in the mail. This notice is sent by companies that handle bills for Medicare. The notice lists the amount you may be billed.

* New Medicare premium rates become effective every year in January. If you get Social Security or Railroad Retirement Board benefits, the new premium rates are sent to you each December with your cost of living adjustment notice. After December 1, you can also get the new Medicare rates for the following year by looking at www.medicare.gov on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in blue are defined on pages 45-46.

What is "assignment" in the Original Medicare Plan and why is it important?

Assignment is an agreement between people with Medicare, their doctors and suppliers, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the proper Medicare deductible and coinsurance amounts from the person with Medicare, their other insurance, or anyone else.

If assignment isn't accepted, doctors and providers may charge you more than the Medicare-approved amount. For most services, there is a limit on the amount over the Medicare-approved amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and other health care providers who don't accept assignment is called the limiting charge. The limiting charge is 15% over Medicare's approved amount. The limiting charge applies only to certain services and doesn't apply to supplies and equipment. **In addition, you may have to pay the entire charge at the time of service**. Medicare will send you its share of the charge when the claim is processed.

In some cases, your health care providers and suppliers must accept assignment. For example, if you get Medicare-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare program, the pharmacy or supplier must accept assignment.

Caution: If you get your Medicare-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, **Medicare won't pay**.

Doctors and suppliers must submit your claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge you for this service. You can't send in the claim yourself.

For more information about assignment, get a free copy of *Does your doctor or supplier accept "assignment?"* (CMS Pub. No. 10134). Look on page 44 to see how to get this booklet. To find physicians and suppliers who participate in Medicare, look at www.medicare.gov on the web. Select "Participating Physician Directory" or "Supplier Directory." You can also call 1-800-MEDICARE (1-800-633-4227) for this information.

Will I be told if a health care service or supply I need isn't covered?

Yes. In most cases, your doctor, provider, or supplier should give you a written notice before you get items or services that Medicare might not pay for. This written notice is called an Advance Beneficiary Notice (ABN). You should get an ABN when items or services that are usually covered by Medicare are considered not medically necessary. You may also get an ABN when skilled nursing care, home health care, hospice care, or medical equipment and supplies are not covered, in certain cases. The ABN explains what items and services Medicare won't pay for and why. Information on the ABN helps you choose whether you want to get the item or service, even if you might have to pay for it yourself.

You won't get an ABN for items and services that are never covered by Medicare. Your doctor, provider, or supplier may give you a written notice of non-covered items and services such as routine vision or dental exams. In cases of items or services excluded from Medicare coverage, you may get a Notice of Exclusion from Medicare Benefits (NEMB), a voluntary-use Medicare notice. If you choose to get items or services not covered by Medicare, you will have to pay for them yourself or through other insurance that you may have, whether or not you get a notice in advance.

What happens if Medicare doesn't pay for a health care service or supply?

Your Medicare Summary Notice (MSN) gives you information about the services or supplies that Medicare won't pay for. A Medicare Summary Notice is a written notice that tells you whether Medicare has paid for a service or supply. Read it carefully. If you believe that Medicare should have paid for the service or supply, you have 120 days from the date you receive the notice to appeal. The back of your Medicare Summary Notice will have information on how you may ask Medicare to make another decision about whether it will pay for the services or supplies you received.

What is a Medigap (Medicare Supplement Insurance) policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Medigap policies must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."

Do I need to buy a Medigap policy?

Medigap policies help pay health care costs only if you have the Original Medicare Plan. Whether you need a Medigap policy is a decision that only you can make. You may want to buy a Medigap policy because the Original Medicare Plan doesn't pay for all of your health care. There are "gaps" or costs you must pay in the Original Medicare Plan. Depending on your health care needs and finances, you may want to continue your employee or retiree coverage, or join a Medicare Advantage Plan.

You don't need to buy a Medigap policy if you are in a Medicare Advantage Plan. In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are in a Medicare Advantage health plan. If you have Medicaid, it is illegal for an insurance company to sell you a Medigap policy except in certain situations.

For more information about Medigap policies, costs, and choices, get a copy of *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (CMS Pub. No. 02110). Look on page 44 to see how to get this booklet.

Can another health plan pay before Medicare?

Yes. For example, if you are covered under an employer group health plan based on your own or a family member's current employment, then the group health plan may pay your health care bills first. For more information about who pays first, get a copy of *Medicare and Other Health Benefits: Your Guide to Who Pays First* (CMS Pub. No. 02179). See page 44 for details about how to get this booklet.

Can I get help from my state to pay my health care costs?

Millions of people with Medicare save money each year through the Medicare Savings Program. Your state may also have programs for people with limited income and resources that pay Medicare premiums, and in some cases, may also pay Medicare deductibles and coinsurance.

You can apply for these programs if

- You have Medicare Part A. If you are paying a premium for Medicare Part A, but can't afford it, the Medicare Savings Program may pay the Medicare Part A premium for you; and
- You are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include things like money in a checking or savings account, stocks, or bonds; and
- You are an individual with a monthly income of less than $1,068,* or are a couple with a monthly income of less than $1,426.*

* Income limits will change slightly in 2005. If you live in Alaska or Hawaii, income limits are slightly higher.

Call your State Medical Assistance Office. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure.

Note: Individual states may have more generous income and/or resource requirements.

Medicare Savings Programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

Medicaid

If your income and resources are even more limited than those described on page 10, you may qualify for Medicaid. Most of your health care costs are covered if you have Medicare and Medicaid. Medicaid is a joint federal and state program that helps pay medical costs for some people with limited income and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for things like nursing home care, home care, and outpatient prescription drugs that aren't covered by Medicare. For more information about Medicaid, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

PACE (Programs of All-inclusive Care for the Elderly)

PACE combines medical, social, and long-term care services for frail people. To be eligible, you must be age 55 or older, live in the service area of a PACE program, and be certified as needing the level of care required for nursing home services in your state. You may have Medicare or Medicaid, or both, Medicare and Medicaid. PACE is available only in states that have chosen to offer it under Medicaid. For more information about PACE, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

For Medicare to cover a service or supply, you must:

- Have the part of Medicare (Part A or Part B) that covers the particular service or supply;
- Need the service or supply for a health condition that is medically necessary;
  Medically necessary services or supplies
  - Are proper and needed for the diagnosis or treatment of your medical condition;
  - Are provided for the diagnosis, direct care, and treatment of your medical condition;
  - Meet the standards of good medical practice in the local area; and
  - Aren't mainly for the convenience of you or your doctor.

and

- Meet certain conditions that apply. In some cases, there may be a limit on how often the service or supply is covered.

THE ORIGINAL MEDICARE PLAN

How does Medicare decide what's covered?

At times, Medicare makes a national coverage decision about whether to cover a medical service or equipment after reviewing information about how a service or equipment improves health or helps manage a health problem. If Medicare makes a decision that applies to all people with Medicare, it is called a "National Coverage Determination."

There may be a Local Coverage Determination that explains if a service is covered in your area and when it is considered medically necessary. For more information about National Coverage Determination, look at www.medicare.gov on the web. Select "Your Medicare Coverage" and the supply or service you need. Or, call 1-800-MEDICARE (1-800-633-4227).

Original Medicare Plan Coverage Charts

On the following pages are charts that list

- Some of the services and supplies the Original Medicare Plan covers,
- The conditions that must be met for some services or supplies to be covered,
- How often the services or supplies are covered (limits),
- How much you pay, and
- Some of the services and supplies the Original Medicare Plan doesn't cover.

Page 13 explains how to read the charts.

If a service or supply isn't listed on the charts, call 1-800-MEDICARE (1-800-633-4227) for information about the type of service or supply you need. TTY users should call 1-877-486-2048. You can also find out what services or supplies are covered by Medicare by looking at www.medicare.gov on the web. Select "Your Medicare Coverage."

THE ORIGINAL MEDICARE PLAN

How to Read the Charts: This is a **SAMPLE** of the charts on pages 14-43 that explains your coverage in the Original Medicare Plan.

Name of service or supply is listed alphabetically.

Explains whether Medicare covers the service or supply, any conditions that must be met before Medicare will cover it, and limits to the coverage.

	Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
A	**Acupuncture**	Not covered by Medicare.	100% of the costs.	
	Chiropractic Services	Medicare covers manipulation of the spine to correct a subluxation, when provided by chiropractors or other qualified providers.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B

Services and supplies are listed alphabetically. Letter tabs help you find the service or supply you need.

The part of the charge you pay in 2004. Amounts change in 2005. It can't be shown as a dollar amount since costs vary. If you have a Medigap policy (see page 9) or other health coverage in addition to Medicare, this amount may be paid in full or in part by the policy.

Words in blue are defined on pages 45-46.

If the service or supply is covered, this column shows which part of Medicare pays for the service or supply. If you have both Medicare Part A and Part B, you don't need to pay attention to this column. However, if you only have one part, you need to look carefully to see if you are covered.

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

THE ORIGINAL MEDICARE PLAN

A

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Acupuncture	Not covered by Medicare.	You pay 100%.	
Ambulance Services	Medicare covers limited ambulance services. If you need to go to a hospital or skilled nursing facility (SNF), ambulance services are covered **only if transportation in any other vehicle would endanger your health.** Generally, transportation from a hospital or SNF isn't covered. If the care you need isn't available locally, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the care you need. If you choose to go to another facility farther away, Medicare payment is based on how much it would cost to go to the closest facility. All ambulance suppliers must accept assignment. **Medicare doesn't pay for ambulance transportation to a doctor's office.** Air ambulance is paid only in emergency situations. If you could have gone by land ambulance without serious danger to your life or health, Medicare pays only the land ambulance rate and you are responsible for the difference.	You pay 20% of the Medicare-approved amount. (1)*	B
Ambulatory Surgical Centers	Medicare covers services given in an Ambulatory Surgical Center for a covered surgical procedure.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
Anesthesia	Anesthesia services (outside of doctors charges) are covered along with medical and surgical benefits. **Medicare Part A covers anesthesia you get while in an inpatient hospital.** Medicare Part B covers anesthesia you get as an outpatient.	You pay 20% of the Medicare-approved amount for hospital outpatient service. (1)*(2)**	A & B

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Artificial Limbs and Eye	Medicare helps pay for artificial limbs and eyes. For more information, see Prosthetic Devices on page 37.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
Blood	Medicare will cover all but the first three pints of blood. Part A covers blood you get as an inpatient, and Part B covers blood you get as an outpatient and in a freestanding Ambulatory Surgical Center.	You pay for the first three pints of blood, unless you or someone else donates blood to replace what you use. After the first three pints of blood you pay 20% of the Medicare-approved amount. (1)*(2)**	A & B
Bone Mass Measurement	Medicare covers bone mass measurements ordered by a doctor or qualified practitioner who is treating you if you meet one or more of the following conditions: (Women) • You are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on your medical history and other findings. (Men and Women) • Your x-rays show previous osteoporosis, osteopenia, or vertebrae fractures. • You are on prednisone or steroid-type drugs or are planning to begin such treatment. • You have been diagnosed with primary hyperparathyroidism. • You are being treated with a drug for osteoporosis, to see if the therapy is working. The test is covered every 24 months for qualified individuals and, more frequently if medically necessary.	You pay 20% of the Medicare-approved amount. (1)*(2)** In the hospital setting, you pay a set copayment amount. (1)*	B
Braces (arm, leg, back, and neck)	Medicare covers arm, leg, back, and neck braces. For more information, see Prosthetic Devices on page 37.	See page 37.	B

A

B

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
B	**Breast Prostheses**	Medicare covers breast prostheses (including a surgical brassiere) after a mastectomy. For more information, see Prosthetic Devices on page 37.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
C	**Cane/Crutches**	Medicare covers canes and crutches. Medicare doesn't cover white canes for the blind. For more information, see Durable Medical Equipment on pages 23-24.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
	Cardiac Rehabilitation Programs	Exercise programs are covered for patients, referred by a doctor, who have: 1) had a heart attack in the last 12 months, 2) had coronary bypass surgery, and/or 3) stable angina pectoris. These programs may be given by the outpatient department of a hospital or in doctor-directed clinics.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
	Chemotherapy	Chemotherapy is covered for patients who are hospital inpatients or outpatients or patients in a doctor's office or in free-standing clinics. In a hospital inpatient setting, Part A covers chemotherapy. In a hospital outpatient setting or a free-standing facility or a doctor's office, chemotherapy is covered by Part B.	You pay 20% of the Medicare-approved amount. (1)*(2)** You pay a set copayment amount in the hospital outpatient setting. (1)*	A or B A B
	Chiropractic Services	Medicare covers manipulation of the spine to correct a subluxation when provided by chiropractors or other qualified providers.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
	Clinical Trials	Medicare covers routine costs, like doctor visits and tests, if you take part in a qualifying clinical trial. In most cases, Medicare doesn't pay for the experimental item being investigated. Clinical trials test new types of medical care, like how well a new cancer drug works. Clinical trials help doctors and researchers see if the new care works and if it is safe. To order a free booklet about Medicare's coverage of clinical trials, see page 44.	You pay the part of the charge that you would normally pay for covered services.	A & B

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Colorectal Cancer Screening	Medicare covers several colorectal cancer screening tests. Talk with your doctor about the screening test that is right for you. All people age 50 and older with Medicare are covered. However, there is no minimum age for having a colonoscopy. Colorectal cancer is the second leading cancer killer in the United States, but it is also one of the most preventable cancers. Screening tests can help prevent colorectal cancer by finding pre-cancerous polyps so they can be removed before they turn into cancer. More than one-third of colorectal deaths could be avoided if people over 50 had regular screening tests.		
	Colonoscopy: Medicare covers this test once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, the test is covered once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.	You pay 20% of the Medicare-approved amount. You pay 25% of the Medicare-approved amount if the test is done in a hospital outpatient department. (1)*(2)**	B
	Fecal Occult Blood Test: Medicare covers this test once every 12 months.	You pay nothing for a fecal occult blood test.	B
	Flexible Sigmoidoscopy: Medicare covers this test once every 48 months.	You pay 20% of the Medicare-approved amount. You pay 25% of the Medicare-approved amount if the test is done in a hospital outpatient department.	B
	Barium Enema: Doctors can use this instead of a flexible sigmoidoscopy or colonoscopy. It's covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	You pay 20% of the Medicare-approved amount.	B
Commode Chairs	Medicare covers durable medical equipment (DME) like commode chairs that your doctor orders for use in your home. For more information, see Durable Medical Equipment on pages 23-24.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
Cosmetic Surgery	Cosmetic surgery is generally not covered unless it is needed because of accidental injury or to improve the function of a malformed part of the body.	Generally, you pay 100% for cosmetic surgery.	

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
C	**Custodial Care** (help with activities of daily living, like bathing, dressing, using the bathroom, and eating)	Medicare doesn't cover custodial care when that is the only kind of care you need. "Care" is considered custodial when it's for the purpose of helping you with activities of daily living or personal needs that could be done safely and reasonably by people without professional skills or training. For example, custodial care includes help getting in and out of bed, bathing, dressing, eating, and taking medicine. Medicare does cover limited skilled nursing facility care under certain conditions. For more information, see Skilled Nursing Facility Care on pages 39-41.	In general, you pay 100%.	
D	**Dental Services**	Medicare doesn't cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. Medicare doesn't pay for dental plates or other dental devices. Medicare Part A will pay for certain dental services that you get when you are in the hospital. Medicare Part A can pay for hospital stays if you need to have emergency or complicated dental procedures, even when the dental care itself isn't covered. Call your Fiscal Intermediary for more information. To get their telephone number call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.	In general, you pay 100%.	
	Diabetes Supplies and Services	**Diabetes Supplies:** Medicare covers some diabetes supplies. These include • blood glucose test strips • blood glucose monitor • lancet devices and lancets • glucose control solutions for checking the accuracy of test strips and monitors. (See blood glucose monitor coverage under Durable Medicare Equipment on pages 23-24). There may be limits on how much or how often you get these supplies.	You pay 20% of the Medicare-approved amount. (1)*(2)** **(continued)**	B

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Diabetes Supplies and Services (continued)	To make sure your Medicare diabetes medical supplies are covered: • Only accept supplies you have ordered. Medicare won't pay for supplies you didn't request. • Make sure you request your supply refills. Medicare won't pay for supplies sent from the supplier to you automatically. • All Medicare-enrolled pharmacies and suppliers must submit claims for glucose test strips. You can't send in the claim yourself.		B
	Syringes and insulin (unless used with an insulin pump), insulin pens, needles, alcohol swabs, gauze, eye exams for glasses, and routine or yearly physical exams aren't covered. If you use an insulin pump, insulin and the pump could be covered as durable medical equipment. There may be some limits on covered supplies or how often you get them.	You pay 100% for insulin (unless used in a pump), syringes, and needles.	B
	Therapeutic Shoes or Inserts: Medicare covers therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. The shoes and inserts must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, or pedorthist. Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts. The fitting of the shoes or inserts is covered in the Medicare payment for the shoes.	You pay 20% of the Medicare-approved amount. (1)*(2)**	
	For more information about diabetes supplies, call your Durable Medical Equipment Regional Carrier (DMERC). To get their telephone number call 1-800-MEDICARE (1-800-633-4227).		
	(continued)		

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** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
D **Diabetes Supplies and Services** (continued)	**Diabetes Services:**		
	• **Diabetes Self-Management Training:** Diabetes outpatient self-management training is a covered program to teach you to manage your diabetes. It includes education about self-monitoring of blood glucose, diet, exercise, and insulin. Training is covered if you are newly diagnosed with diabetes, or are newly eligible for Medicare, or are at significant risk for complications from the diabetes, and your doctor gives you a referral for this service. Medicare Part B covers diabetic self-management training from a Medicare-approved training program.	You pay 20% of the Medicare-approved amount for outpatient facility charges or doctors' services. (1)*(2)**	B
	• **Yearly Eye Exam:** Medicare covers yearly eye exams for diabetic retinopathy.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
	• **Foot Exam:** A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations, as long as you haven't seen a foot care professional for another reason between visits.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
	• **Glaucoma Screening:** Medicare covers glaucoma screening every 12 months for people with diabetes or a family history of glaucoma, or African Americans age 50 and older.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
	• **Medical Nutrition Therapy Services:** Medical nutrition therapy services are covered for people with diabetes (or kidney disease) when referred by a doctor. Medical nutrition therapy services are covered for three years after a kidney transplant. These services can be given by a registered dietician or Medicare-approved nutrition professional and include a nutritional assessment and counseling to help you manage your diabetes.	You pay 20% of the Medicare-approved amount for services. (1)*(2)**	B
	(continued)		

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** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Diabetes Supplies and Services (continued)	For more information about diabetes outpatient self-management training from a Medicare-certified program, routine foot care, glaucoma screening, an eye exam for diabetic retinopathy, or medical nutrition therapy services, call your Medicare Carrier. For more information about diabetes outpatient self-management training in an outpatient facility, call your Fiscal Intermediary. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). To order a free booklet about Medicare's coverage of diabetes services and supplies, see page 44.		
Diagnostic Tests, X-rays, and Lab Services	Medicare covers diagnostic tests like CT scans, MRIs, EKGs, and X-rays. Medicare also covers clinical diagnostic tests and lab services provided by certified laboratories that are participating in Medicare. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare doesn't cover most routine screening tests, like checking your hearing. Some preventive tests and screenings are covered by Medicare. See Preventive Services on page 37. (Preventive tests and screenings are done to help prevent an illness or condition, or to diagnose it early, before you have symptoms.)	You pay 20% of the Medicare-approved amount for covered diagnostic tests and x-rays. (1)*(2)** You pay a set copayment amount for diagnostic tests and x-rays in the hospital outpatient setting. (1)* You pay $0 for Medicare-covered lab services.	B B
Dialysis (Kidney)	Medicare covers some kidney dialysis services and supplies, including • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Certain home support services (may include visits by trained dialysis workers to check on your home dialysis, help in emergencies when needed, and check your dialysis equipment and water supply). **(continued)**	 See Hospital Care (Inpatient) on pages 29-30. You pay 20% of the cost. If you deal with a supplier (not the dialysis facility), the $100 (in 2004) deductible applies.	A B

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** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
D **Dialysis (Kidney)** (continued)	• Certain drugs for home dialysis, including Heparin, the antidote for Heparin when medically necessary, topical anesthetics, and Erythropoietin (Epogen®) or Epoetin alfa.	If you deal with the dialysis facility, these drugs may be included in the cost of dialysis. If you deal with a supplier, you pay 20% of the Medicare-approved amount. (1)*(2)**	B
	• Outpatient maintenance dialysis treatments (when you get treatments in any Medicare-approved dialysis facility).	You pay 20% of the per treatment rate. (1)*	B
	• Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).	You pay 20% of the training costs. (1)*(2)**	B
	• Home dialysis equipment and supplies (like alcohol, wipes, sterile drapes, rubber gloves, and scissors). To order a free booklet about Medicare's coverage of kidney dialysis, see page 44.	Generally, you pay 20% of the cost to buy or rent equipment and supplies. If you deal with a medical supply company (MSC) (not the dialysis facility), the $100 (in 2004) deductible applies and your MSC must accept assignment.	
Doctor's Office Visits	Medicare covers medically necessary services you get from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location. **Routine annual physicals and gynecological (GYN) exams aren't covered.** Some preventive tests and screenings are covered by Medicare. See Preventive Services on page 37, and Pap Test/Pelvic Exam on page 34.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
Drugs	See Prescription Drugs (Outpatient) on pages 35-36.		

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Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Durable Medical Equipment (DME)	Medicare covers durable medical equipment (DME) that your doctor prescribes for use in your home. Only your own doctor can prescribe medical equipment for you. Durable Medical Equipment is • Durable (is long lasting). • Used for a medical reason. • Not usually useful to someone who isn't sick or injured. • Used in your home. **(continued)**	The amount you pay varies. Call your Durable Medical Equipment Regional Carrier (DMERC) for more information. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). Medicare pays for different kinds of DME in different ways; some equipment must be rented, other equipment must be purchased, and for some equipment you may choose rental or purchase. If a supplier of DME doesn't accept assignment (see page 8), there is no limit to what can be charged. You also may have to pay the entire bill (your share and Medicare's share) at the time you get the DME. **Note:** Ask if the supplier is a participating supplier in the Medicare program before you get durable medical equipment. If the supplier is a participating supplier, they **must** accept assignment. If the supplier is enrolled in Medicare but isn't "participating," they have the option to accept assignment. If the supplier isn't enrolled in Medicare, Medicare **won't** pay your claim.	B

Note: There may be Medicare Advantage Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

	Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
D	**Durable Medical Equipment (DME)** (continued)	Covered Durable Medical Equipment includes, but isn't limited to • Air-fluidized beds • Blood glucose monitors • Canes (white canes for the blind aren't covered) • Commode chairs • Crutches • Home oxygen equipment and supplies • Hospital beds • Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary) • Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary) • Patient lifts (to lift patient from bed or wheelchair by hydraulic operation) • Suction pumps • Traction equipment • Walkers • Wheelchairs Make sure your supplier is enrolled in Medicare and has a Medicare supplier number. Suppliers have to meet strict standards to qualify for a Medicare supplier number. Medicare won't pay your claim if your supplier doesn't have one, even if your supplier is a large chain or department store that sells more than just durable medical equipment.		
E	**Emergency Room Services**	A medical emergency is when you believe that your health is in serious danger. You may have a bad injury, sudden illness, or an illness quickly getting much worse. Medicare covers emergency room services. Emergency services aren't covered in foreign countries, except in some instances in Canada and Mexico. For more information, see Travel on pages 42-43. (continued)	You pay a set copayment amount for each emergency room visit; you don't pay this amount if you are admitted to the hospital for the same condition within 1-3 days of the emergency room visit. (1)*(2)**	B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Emergency Room Services (continued)	Emergency room visits usually include both facility charges and doctor's charges. Note: If you are admitted to the hospital within 1-3 days of the emergency room visit for the same condition, the emergency room visit is included in the inpatient hospital care charges, not charged separately.	You pay 20% of the charges. (1)*(2)**	B
Equipment	See Durable Medical Equipment on pages 23-24.	See Durable Medical Equipment.	B
Eye Exams	Medicare doesn't cover routine eye exams. Some preventive eye tests and screenings are covered by Medicare. See Yearly Eye Exams under Diabetes Supplies and Services on page 20. See Glaucoma Screening on page 26. See Macular Degeneration on page 30.	You pay 100% for routine eye exams.	
Eyeglasses/ Contact Lenses	Generally, Medicare doesn't cover eyeglasses or contact lenses. However, **following cataract surgery with an intraocular lens,** Medicare helps pay for cataract glasses, contact lenses, or intraocular lenses provided by an optometrist, if the optometrist is authorized to provide this service in your state. Important: • Only standard frames are covered. • Lenses are covered even if you had the surgery before you had Medicare. • Payment may be made for lenses for both eyes even though cataract surgery involved only one eye.	You pay 100%. You pay $0 for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. (1)*(2)** You pay any additional cost for upgraded frames.	B

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THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
F	**Flu Shot**	Medicare covers one flu shot per flu season. You can get a flu shot in the winter and the fall flu season of the same calendar year. All people with Medicare are covered.	You pay $0 for a flu shot if the doctor or health care provider accepts assignment.	B
	Foot Care	Medicare generally doesn't cover routine foot care. Medicare Part B covers the services of a podiatrist (foot doctor) for medically necessary treatment of injuries or diseases of the foot (such as hammer toe or bunion deformities and heel spurs). See Therapeutic Shoes and Foot Exam under Diabetes Supplies and Services on pages 18-21.	You pay 100%. You pay 20% of the Medicare-approved amount. (1)*(2)**	B
G	**Glaucoma Screening**	Medicare covers glaucoma screening once every 12 months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African Americans who are age 50 and older. The screening must be done or supervised by an eye doctor who is legally allowed to do this service in your state.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
H	**Health Education/Wellness Programs**	Medicare generally doesn't cover health education and wellness programs.	Generally, you pay 100%.	
	Hearing Exams/ Hearing Aids	Medicare doesn't cover routine hearing exams or hearing aids. In some cases, diagnostic hearing exams are covered by Part B.	You pay 100% for routine hearing exams and hearing aids. You pay 20% of the Medicare-approved amount for diagnostic hearing exams. (1)*(2)**	 B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Home Health Care	Home Health Care is skilled nursing care and certain other health care services you get in your home for the treatment of an illness or injury. Medicare covers some home health care if • Your doctor decides you need medical care in your home and makes a plan for your care at home; and • You need at least one of the following: intermittent (and not full time) skilled nursing care, physical therapy or speech language pathology services, or a continued need for occupational therapy; and • You are homebound. This means you are normally unable to leave home and that leaving home is a major effort. When you leave home, it must be infrequent, for a short time. You may attend religious services. You may leave the house to get medical treatment, including therapeutic or psychosocial care. You can also get care in an adult day care program that is licensed or certified by your state or accredited to furnish adult day care services in your state; and • The home health agency caring for you must be approved by the Medicare program.	You pay $0 for all covered home health visits.	A or B, if you only have B
	Medicare covers durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers)	You pay 20% of the Medicare-approved amount for durable medical equipment.	B
	Note for Women with Osteoporosis: Under Medicare's home health coverage, Medicare helps pay for an injectable drug for osteoporosis in women who have Medicare Part B, and who meet the criteria for the Medicare home health benefit, and who have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. You must also be certified by a doctor as unable to learn, or as physically or mentally unable to give yourself the drug by injection, and that family and/or caregivers are unable or unwilling to give the drug by injection.	You pay 20% of the Medicare-approved cost of the drug.	A & B if you are under a home health care plan

(continued)

H

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Home Health Care (continued)	Medicare also covers the visit by a home health nurse to give the drug. To order a free booklet about Medicare's coverage of home health care, see page 44.	You pay $0 for the visit by a home health nurse to give the drug.	A or B
Hospice Care	Hospice is a special way of caring for people who are terminally ill and for their families. This care includes physical care and counseling. The goal of hospice is to care for you and your family, not to cure your illness.	You pay $0 for hospice care. You pay a copayment of up to $5 for outpatient prescription drugs.	A A
	Medicare covers hospice care if • You are eligible for Medicare Part A; and • Your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live; and • You sign a statement choosing hospice care instead of routine Medicare covered benefits for your terminal illness; and • You get care from a Medicare-approved hospice program. **Rural Hospice Care:** Medicare allows a nurse practioner to serve as an attending physician for a patient who elects the hospice benefit. Nurse practioners are prohibited from certifying a terminal diagnosis.	Room and board aren't covered by Medicare if you get hospice care in your home, or if you live in a nursing home or a hospice residential facility. In certain cases, depending on the level of service provided, the costs for room and board are included in Medicare's payment (for example, when a hospice patient is admitted to a hospital or skilled nursing facility for the inpatient or respite level of care).	
	Respite Care: Medicare also covers respite care if you are getting covered hospice care. Respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. You can stay in a Medicare-approved facility, such as a hospice facility, hospital or nursing home, up to five days each time you get respite care. There is no limit to the number of times you can get respite care. **(continued)**	You pay 5% of the Medicare-approved amount for inpatient respite care. The amount you pay for respite care can change each year.	A

Note: There may be Medicare Advantage Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Hospice Care (continued)	Medicare will still pay for covered services for any health problems that aren't related to your terminal illness. To order a free booklet about Medicare's coverage of hospice care, see page 44.		
Hospital Bed	See Durable Medical Equipment on pages 23-24.		
Hospital Care (Inpatient) (For Outpatient Services, see pages 32-33)	Medicare Part A covers inpatient hospital care when all of the following are true: • A doctor says you need inpatient hospital care for treatment of your illness or injury. • You need the kind of care that can be given only in a hospital. • The hospital has agreed to participate in the Medicare program. • The Utilization Review Committee of the hospital doesn't disapprove your stay while you are in the hospital. • A Quality Improvement Organization or an intermediary doesn't disapprove your stay after the bill is submitted. (continued)	You pay for each benefit period in 2004: Days 1 - 60: a total deductible of $876 Days 61 - 90: $219 each day Days 91 - 150: $438 each day Beyond 150 days: all costs A benefit period begins the day you go to a hospital (or under special circumstances, a skilled nursing facility). The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Lifetime reserve days give you an extra 60 days of inpatient coverage when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime.	A

Note: There may be Medicare Advantage Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

	Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
H	**Hospital Care** (Inpatient) **(continued)**	Medicare-covered hospital services include: a semiprivate room, meals, general nursing, and other hospital services and supplies. This includes care you get in critical access hospitals and inpatient mental health care. This doesn't include private duty nursing or a television or telephone in your room. It also doesn't include a private room, unless medically necessary.	You pay for private daily nursing and television in your room. You pay for a private room unless it is medically necessary.	
L	**Lab Services**	Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. For more information, see Diagnostic Tests on page 21.	You pay $0 for Medicare-approved services.	B
M	**Macular Degeneration**	Medicare covers a treatment for some patients with age-related macular degeneration. This treatment is called ocular photodynamic therapy with verteporfin.	You pay 20% of the Medicare approved amount for diagnosis and treatment of diseases and conditions of the eye. (1)*(2)**	B
	Mammogram Screening	Medicare covers a mammogram screening once every 12 months (11 full months must have gone by from the last screening) for all women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39. Medicare covers digital technologies for mammogram screenings.	You pay 20% of the Medicare-approved amount with no Part B deductible. (2)** You pay 20% of the Medicare-approved amount with no Part B deductible. (2)** You pay a set copayment amount in the hospital outpatient setting. (1)*	B B
	Mental Health Care	Medicare covers mental health care given by a doctor or a qualified mental health professional. Before you get treatment, ask your doctor, psychologist, social worker, or other health professional if they accept Medicare payment. **(continued)**		

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Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Mental Health Care (continued)	**Inpatient Mental Health Care:** Medicare covers inpatient mental health care services. These services can be given in a general hospital or in a specialty psychiatric hospital that only cares for people with mental health problems. Medicare helps pay for inpatient mental health services in the same way that it pays for all other inpatient hospital care. **Note:** If you are in a specialty psychiatric hospital, Medicare only helps for a total (lifetime limit) of 190 days of inpatient care.	You pay the same deductible and copayments as inpatient hospital care. See page 29 for the deductible and copayment amounts.	A
	Outpatient Mental Health Care: Medicare covers mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department.	You usually pay 50% of the Medicare-approved amount. (1)*(2)** You pay a separate copayment amount for the facility service. (1)*	B
	Partial Hospitalization: Partial hospitalization for mental health care is a structured program of active treatment that is more intense than the care you get in your doctor's or therapist's office. For Medicare to cover a partial hospitalization program, a doctor must say that you would otherwise need inpatient treatment. To order a free booklet about Medicare's coverage of mental health care, see page 44.	You pay a set copayment amount for each day of service. (1)*(2)**	B
	Medicare covers the services of specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, as allowed by state and local law for medically necessary services.	You pay 20% of the Medicare-approved amount for certain services, for example for medication management or diagnostic testing. (1)*(2)** You pay 50% of the Medicare-approved amounts for mental health therapy services.	B

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THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
N			
Nursing Home Care	Most nursing home care is custodial care. Generally, Medicare doesn't cover custodial care. Medicare Part A only covers skilled care given in a certified skilled nursing facility (SNF). You must meet certain conditions, and coverage is limited. See Skilled Nursing Facility Care on pages 39-40.	You pay 100%.	
Nutrition Therapy Services (Medical)	Medicare covers medical nutrition therapy services, when it is ordered by a doctor, for people with kidney disease (but who aren't on dialysis) or who have a kidney transplant, or people with diabetes. These services can be given by a registered dietician or Medicare-approved nutrition professional and include nutritional assessment and counseling. See Diabetes Services and Supplies on pages 18-21.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
O			
Occupational Therapy	See Physical/Occupational/Speech Therapy on page 34.		
Ostomy Supplies	Medicare covers ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need, based on your condition. Call your Durable Medical Equipment Regional Carrier (DMERC) for more information. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).	You pay 20% of the Medicare-approved amount for the doctor's services and supplies. (1)*(2)**	B
Outpatient Hospital Services	Medicare Part B covers medically necessary services you get as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include • Services in an emergency room or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital	You pay 20% of the Medicare-approved amount for the doctor. (1)*(2)** For other than doctors' services, you pay a set copayment amount based on each service received. **(continued)**	B B

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Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Outpatient Hospital Services (continued)	• Mental health care in a partial hospitalization program, if a physician certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospitals • Medical supplies such as splints and casts • Drugs and biologicals that you can't give yourself	To order a free booklet about Medicare's payment of outpatient services, see page 44.	
Oxygen Therapy	Medicare covers rental of oxygen equipment; or if you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen under these conditions: • Your doctor says you have a severe lung disease or you're not getting enough oxygen and your condition might improve with oxygen therapy. • Your arterial blood gas level falls within a certain range. • Other alternative measures have been tried and failed or weren't helpful for you. Under the above conditions Medicare helps pay for • Systems for furnishing oxygen • Containers that store oxygen • Tubing and related supplies for the delivery of oxygen • Oxygen contents If oxygen is provided only for use during sleep, portable oxygen wouldn't be covered. Portable oxygen isn't covered when provided only as a backup to a stationary oxygen system. Call your Durable Medical Equipment Regional Carrier (DMERC) for more information. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).	You pay 20% of the Medicare-approved amount. (1)*(2)**	B

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P

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Pap Test/Pelvic Exam	Medicare covers Pap tests and Pelvic exams (and a clinical breast exam) for all women once every 24 months. Medicare covers this test and exam once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months. If you have your Pap test, pelvic exam, and clinical breast exam on the same visit as a routine physical exam, you pay for the physical exam. Routine physical exams aren't covered by Medicare. To order a free booklet about Medicare's coverage for women, see page 44.	You pay $0 for the lab Pap test. (2)** You pay 20% of the Medicare-approved amount (or a copayment) for the part of the exam when the doctor or health care provider collects the specimen and for the pelvic exam. (2)** If the pelvic exam was provided in a hospital outpatient department, you pay a set copayment amount.	B
Physical Exams (Routine)	Routine physical exams aren't covered by Medicare. If your Medicare Part B begins on or after January 1, 2005, Medicare will cover a one-time preventive physical exam within the first six months that you have Medicare Part B.	You pay 100% for routine physical exams. You pay 20% of the Medicare-approved amount. (1)*(2)**	
Physical/ Occupational/ Speech Therapy	Medicare helps pay for medically necessary outpatient physical and occupational therapy and speech pathology services when • Your doctor or therapist sets up the plan of treatment, and • Your doctor periodically reviews the plan to see how long you will need therapy. You can get outpatient services from a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. Also, you can get services from a Medicare-approved physical or occupational therapist, in private practice, in his or her office or in your home. (Medicare doesn't pay for services given by a speech pathologist in private practice.) There is no limit to the amount of medically necessary outpatient physical therapy, occupational therapy, or speech-language pathology services you may get. You can get these services from any Medicare-approved outpatient provider.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Prescription Drugs (Outpatient) Very Limited Coverage	Medicare **doesn't** cover most prescription drugs. Medicare covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on Medicare-covered prescription drugs. Medicare-approved drug discount cards will be available for purchase after May 2004.	You pay 100% for most prescription drugs.	
	The following outpatient prescription drugs are covered: • **Some Antigens:** Medicare will help pay for antigens if they are prepared by a doctor and given by a properly instructed person (who could be the patient) under doctor supervision. • **Osteoporosis Drugs:** Medicare helps pay for an injectable drug for osteoporosis for certain women with Medicare. See note for women with osteoporosis, under Home Health Care on page 27. • **Erythropoietin (Epogen®) or Epoetin alfa:** Medicare will help pay for erythropoietin by injection if you have End-Stage Renal Disease (permanent kidney failure) and need this drug to treat anemia. • **Hemophilia Clotting Factors:** If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection. • **Injectable Drugs:** Medicare covers most injectable drugs given by a licensed medical practitioner. • **Immunosuppressive Drugs:** Medicare covers immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility. **(continued)**	You pay 20% of the Medicare-approved amount for covered prescription drugs. (1)* Coverage is very limited.	B

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
P **Prescription Drugs** (Outpatient) Very Limited Coverage **(continued)**	• **Oral Cancer Drugs:** Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form. Currently, Medicare covers the following cancer drugs you take by mouth • Capecitabine (brand name Xeloda®) • Cyclophosphamide (brand name Cytoxan®) • Methotrexate • Temozolomide (brand name Temodar®) • Busulfan (brand name Myleran®) • Etoposide (brand name VePesid®) • Melphalan (brand name Alkeran®) As new cancer drugs and brand names become available, these drugs may be added to the list of covered drugs. • **Oral Anti-Nausea Drugs:** Medicare will help pay for oral anti-nausea drugs if you are getting Medicare-covered cancer drugs you take by mouth. Medicare also covers some drugs used in infusion pumps and nebulizers if considered reasonable and necessary. You should check with your Durable Medical Equipment Regional Carrier (DMERC) for specific coverage information about prescription drugs. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). **Note:** "Prescription Drug and Other Assistance Programs" on www.medicare.gov on the web has information on programs that offer discounts or free medication to persons in need, including State prescription drug assistance programs, programs sponsored by pharmaceutical companies, and disease-specific programs. "Prescription Drug and Other Assistance Programs" also has information on prescription drug benefits from Medicare Managed Care Plans and Medigap policies.		B

Note: There may be Medicare Advantage Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Preventive Services Covered by Medicare	See • Bone Mass Measurement on page 15. • Colorectal Cancer Screening on page 17. • Diabetes Supplies and Services on pages 18-21. • Flu Shot on page 26. • Glaucoma Screening on page 26. • Mammogram Screening on page 30. • Medical Nutrition Therapy on page 32. • Pap Test/Pelvic Exam on page 34. • Prostate Cancer Screening (below). • Shots (vaccinations on pages 38-39) including - flu shot - pneumococcal shot - Hepatitis B shot		B
Prostate Cancer Screening	Medicare covers screening tests once every 12 months for all men age 50 and older with Medicare (coverage begins the day after your 50th birthday). Covered tests include		
	• Digital Rectal Examination	Generally, 20% of the Medicare-approved amount for the digital rectal exam. (1)*(2)**	B
	• Prostate Specific Antigen (PSA) Test	You pay $0 for the PSA test and 20% of the Medicare-approved amount for other related services. (1)*(2)**	B
Prosthetic Devices	Medicare covers prosthetic devices needed to replace a body part or function. These include Medicare-approved corrective lenses needed after a cataract operation (see Eyeglasses/Contact Lenses on page 25), ostomy bags and certain related supplies (see Ostomy Supplies on page 32), and breast prostheses (including a surgical brassiere) after a mastectomy (see Breast Prostheses on page 16).	You pay 20% of the Medicare-approved amount. (1)*(2)**	B

(continued)

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.

** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
P **Prosthetic Devices** (continued)	Medicare also covers artificial limbs and eyes, and arm, leg, back, and neck braces. Medicare doesn't pay for orthopedic shoes unless they are a necessary part of the leg brace and the cost is included in the charge for the brace. Medicare doesn't pay for dental plates or other dental devices. For more information about durable medical equipment, call your Durable Medical Equipment Regional Carrier (DMERC). To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).		
R **Radiation Therapy**	Radiation therapy is covered for patients who are hospital inpatients or outpatients, or patients in freestanding clinics.		A or B
	In the hospital setting, Part A covers radiation therapy.	You pay 20% of the Medicare-approved amount. (1)*(2)**	A
	In a freestanding facility, Part B covers radiation therapy	You pay a set copayment amount for radiation therapy in a hospital outpatient setting or in a freestanding facility.	B
Respite Care	Medicare covers respite care for hospice patients. For more information, see Hospice Care on page 28.		
S **Second Surgical Opinions**	Medicare covers a second opinion before surgery. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare will also help pay for a third opinion if the first and second opinions are different.	You pay 20% of the **Medicare-approved amount**. (1)*(2)** You pay nothing for a second opinion for Ambulatory Surgical Center procedures done in a hospital outpatient department.	B
Shots (Vaccinations)	Medicare covers all people with Medicare for **(continued)**		

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Shots (Vaccinations) (continued)	• Flu Shot - Once per flu season. You can get a flu shot in the fall and the winter flu seasons of the same year. The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year. There is a chance that you may still get the flu, but your symptoms will be less severe.	You pay $0 for flu shots if the doctor or health care provider accepts assignment.	B
	• Pneumococcal Shot (vaccine) - One shot may be all you ever need. Ask your doctor.	You pay $0 for a pneumococcal shot if the doctor or health care provider accepts assignment.	
	• Hepatitis B Shot (vaccine) - Certain people with Medicare at medium to high risk for Hepatitis B.	You pay 20% of the Medicare-approved amount for the Hepatitis B vaccine given in a doctor's office. (1)*(2)** For Hepatitis B shots given in a hospital outpatient department, you pay a set copayment amount.	B
Skilled Nursing Facility (SNF) Care	Medicare covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care include changing sterile dressings and physical therapy. It is given in a Medicare-certified SNF. Care that can be given by non-professional staff isn't considered skilled care. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days). (continued)	You pay the following amounts for each benefit period in 2004 (following at least a related three-day covered hospital stay): Days 1 - 20: $0 for each day. Days 21 - 100: up to $109.50 for each day. Days beyond 100: You pay 100%. There is a limit of 100 days of Medicare Part A SNF coverage in each benefit period.	A

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** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

S

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Skilled Nursing Facility (SNF) Care (continued)	Medicare will cover skilled care only if all these conditions are met: 1. You have Medicare Part A (Hospital Insurance) and have days left in your benefit period to use. 2. You have a qualifying hospital stay. This means an inpatient hospital stay of three consecutive days or more, not including the day you leave the hospital. You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay. After you leave the SNF, if you reenter the same or another SNF within 30 days, you don't need another three-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days. 3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just five or six days a week. (continued)	A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. While you are in the Medicare-certified part of the facility, your therapy sevices (physical therapy, occupational therapy, and speech-language pathology) must be billed by the facility. No other therapy service may be billed by another setting, such as an outpatient hospital. If you leave the Medicare-certified part of the facility, your therapy services in the non-Medicare-certified part of the facility are limited by a specific dollar amount each year unless you get the services from an outpatient hospital.	

Note: There may be Medicare Advantage Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

THE ORIGINAL MEDICARE PLAN

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Skilled Nursing Facility (SNF) Care (continued)	4. You get these skilled services in a SNF that has been certified by Medicare. 5. You need these skilled services for a medical condition that: • Was treated during a qualifying three-day hospital stay, or • Started while you were getting Medicare-covered SNF care. For example, you are in the SNF because you had a stroke, and you develop an infection that requires I.V. antibiotics. To order a free booklet about Medicare's coverage of skilled nursing facility care, see page 44.		
Speech Therapy	See Physical/Occupational/Speech Therapy on page 34.		
Substance Abuse Treatment (Outpatient)	Medicare covers substance abuse treatment in an outpatient treatment center if they have agreed to participate in the Medicare program. See Mental Health Care (Outpatient) on page 30.	See Mental Health Care (Outpatient) on page 30.	B
Supplies	Common medical supplies like bandages and gauze are generally not covered by Medicare. Medicare covers some diabetes and dialysis supplies. See Diabetes Supplies and Services on pages 18-21 and Dialysis (Kidney) on pages 21-22. For items such as walkers, oxygen, and wheelchairs, see Durable Medical Equipment on pages 23-24. Supplies furnished as part of a doctor's service are covered by Medicare, and payment is included in Medicare's doctor payment. Doctors don't bill for supplies.	You pay 100% for most common medical supplies.	 B B
Therapeutic Shoes	See Diabetes Supplies and Services (Therapeutic Shoes) on page 19.		B

S

T

Note: There may be Medicare Advantage Plans in your area that offer extra benefits. Call 1-800-MEDICARE (1-800-633-4227) to find out.

T

Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Transplants (Doctor Services)	Medicare covers doctor services for transplants as listed above.	You pay 20% of Medicare-approved payment amount for doctor services. (1)*(2)**	B
Transplants (Facility Charges)	Medicare covers transplants of the heart, lung, kidney, pancreas, intestine/multivisceral, bone marrow, cornea, and liver under certain conditions and, for some types of transplants, only at Medicare-approved facilities. Medicare only approves facilities for kidney, heart, liver, lung, and intestine/multivisceral transplants. Bone marrow, pancreas, and cornea transplants aren't limited to approved facilities. Transplant coverage includes necessary tests, labs, and exams before surgery for you and the organ donor, follow-up care for you and a live donor, and procurement of organs and tissues. To get a free booklet about Medicare's coverage of kidney transplants, see page 44.	The amount varies. Call your Medicare Carrier for information about cornea and bone marrow transplants. Call your Fiscal Intermediary for information about all other transplants To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). For Inpatient Transplants, see Hospital Care (Inpatient) on pages 29-30.	A for inpatient transplants B for cornea and bone marrow transplants
Transportation (Routine)	Medicare generally doesn't cover transportation to get routine health care. For more information, see Ambulance Services on page 14.	You pay 100% for transportation to get routine health care.	
Travel Outside of the United States (Health Care Coverage During Travel)	The Original Medicare Plan generally doesn't cover health care while you are traveling outside the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States. There are some exceptions. **(continued)**	You pay 100% of charges. Health care services and supplies are NOT covered outside the United States except under limited circumstances.	

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Service or Supply	What is covered, and when?	What do YOU pay in 2004?	Part A or B
Travel Outside of the United States (Health Care Coverage During Travel) (continued)	In rare cases, Medicare can pay for inpatient hospital services that you get in Canada or Mexico. Medicare can pay only if: 1. You are in the United States when a medical emergency occurs and the Canadian or Mexican hospital is closer than the nearest United States hospital that can treat the emergency. 2. You are traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest United States hospital that can treat the emergency. 3. You live in the United States and the Canadian or Mexican hospital is closer to your home than the nearest United States hospital that can treat your medical condition, regardless of whether an emergency exists. Medicare also pays for doctor and ambulance services you get in Canada or Mexico as part of a covered inpatient hospital stay. To order a free booklet about Medicare's coverage outside the United States, see page 44.	You pay the part of the charge that you would normally pay for covered services.	A for inpatient services B for outpatient services
Walker/Wheelchair	Medicare covers walkers and wheelchairs as durable medical equipment (DME) that your doctor prescribes for use in your home. For more information, see Durable Medical Equipment on pages 23-24. **Power Wheelchair:** You must have a face-to-face examination and a written prescription from a physician before Medicare helps pay for a power wheelchair.	You pay 20% of the Medicare-approved amount. (1)*(2)**	B
X-rays	Medicare covers medically necessary diagnostic x-rays that are ordered by your treating doctor. For more information, see Diagnostic Tests on page 21.	You pay 20% of the Medicare-approved amount. (1)*(2)** For x-rays in a hospital outpatient setting, you pay a set copayment amount.	B B

T W X

* (1) In 2004, you must pay an annual $100 deductible for Part B services and supplies before Medicare begins to pay its share.
** (2) Actual amounts you must pay may be higher if doctors, health care providers, or suppliers don't accept assignment.

FOR MORE INFORMATION

Free Booklets About Medicare and Related Topics

Health care decisions are important. Medicare tries to give you information to help you make good health care decisions. You can look at or order free booklets from Medicare to learn more about the topics that are of interest to you.

To get these booklets

1. Look at www.medicare.gov on the web. Select "Publications." You can read, print, or order these booklets. This is the fastest way to get a copy.

2. Call 1-800-MEDICARE (1-800-633-4227). Follow the instructions to get a publication. TTY users should call 1-877-486-2048. You will get your copy within three weeks.

3. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov on the web and select "Mailing List" at the top of the page.

Note: Some booklets may not be available in print, but all will be available at www.medicare.gov on the web.

Name of Publication	CMS Pub. No.
Does Your Doctor or Supplier Accept Assignment?	10134
Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare	02110
Medicare & Clinical Trials	02226
Medicare & You	10050
Medicare Coverage of Diabetes Supplies and Services	11022
Medicare Coverage of Kidney Dialysis and Transplant Services	10128
Medicare Coverage of Skilled Nursing Facility Care	10153
Medicare Coverage Outside the United States	10137
Medicare Home Health Care	10969
Medicare Hospice Benefits	02154
Medicare Preventive Services	10110
Medicare and Other Health Benefits: Your Guide to Who Pays First	02179
Medicare and Your Mental Health Care	10184
Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, And Clinical Breast Exam	02248
Your Guide to the Outpatient Prospective Payment System	02118
Your Medicare Rights and Protections	10112

WORDS TO KNOW

Assignment - In the Original Medicare Plan, this means a doctor, other health care provider, or supplier of health care equipment and supplies agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor, provider, or supplier accepts assignment. You still pay your share of the cost of the doctor visit. See page 8 for more assignment information.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Biologicals - Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Critical Access Hospital - A hospital facility to which Medicare has given specific status to provide outpatient and certain inpatient services to people in rural areas.

Deductible - The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

Lifetime Reserve Days - In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital for more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($438 in 2004).

Limiting Charge - In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

WORDS TO KNOW

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies that
- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the local area; and
- aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan (formerly Medicare + Choice Plan) - A program that gives more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare-Approved Amount - In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan - A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Preferred Provider Organization (PPO) Plan - A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan - A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you will pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

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For additional information, call 1-800-MEDICARE (1-800-633-4227). This toll-free 24-hour Helpline is available seven days a week to help you with your Medicare questions. TTY users should call 1-877-486-2048.

¿Necessita usted una copia en español? Llame gratis al 1-800-MEDICARE (1-800-633-4227).